

DOC. NO.  
35-05-20-99/08/20OFFICE OF  
VITAL  
STATISTICS

# CERTIFICATE OF DEATH

## State of Delaware (107)

LOCAL REG NO.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE FILE NUMBER

**DECEDENT**

TO FUNERAL DIRECTOR: After certificate has been signed by attending physician and completely filled in by funeral director, remove carbons, file parts 1 and 2 with Registrar within 72 hrs. after death and then use Burial-Transit Permit for disposition of body.

1. DECEDENT'S NAME (FIRST, MIDDLE, LAST) <b>Marissa R Fishman</b>				2. SEX <b>F</b>		3. DATE OF DEATH (MO., DAY, YR.) <b>12/30/00 8/30/02</b>	
4. SOCIAL SECURITY NO.		5A. AGE (YRS) <b>20</b>		5B. UNDER 1 YEAR MONTHS		5C. UNDER 1 DAY HOURS MINUTES	
6. DATE OF BIRTH (MO., DAY, YR.)		7. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY)		8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO		9. ANATOMICAL GIFT <input type="checkbox"/> CONSENT GRANTED <input type="checkbox"/> NOT GRANTED	
10A. PLACE OF DEATH (CHECK ONLY ONE, SEE INSTRUCTIONS ON OTHER SIDE) <input checked="" type="checkbox"/> INPATIENT <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DOA <input type="checkbox"/> OTHER				10B. FACILITY NAME (IF NOT INSTITUTION GIVE STREET AND NUMBER) <b>A. I. Dupont Hospital for Children</b>		10C. CITY, TOWN, OR LOCATION OF DEATH <b>Wilmington</b>	
10D. COUNTY OF DEATH <b>N.C.</b>		11. MARITAL STATUS — MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPEC.)		12. SURVIVING SPOUSE (IF WIFE GIVE MAIDEN NAME)		13A. DECEDENT'S USUAL OCCUPATION (KIND OF WORK DURING MOST OF WORKING LIFE. DO NOT USE RETIRED)	
13B. KIND OF BUSINESS/INDUSTRY		14A. RESIDENCE — STATE <b>Pennsylvania</b>		14B. COUNTY <b>Chadds Ford</b>		14C. CITY, TOWN, OR LOCATION <b>110 Kelly Drive</b>	
14D. STREET AND NUMBER		14E. INSIDE CITY LIMITS? (YES OR NO)		14F. ZIP CODE		15. WAS DECEDENT OF HISPANIC ORIGIN? (SPECIFY NO OR YES, SPECIFY CUBAN, MEXICAN, PUERTO RICAN, ETC.) <input type="checkbox"/> NO <input type="checkbox"/> YES (Specify) <b>White</b>	
16. RACE — AMERICAN INDIAN, BLACK, WHITE, ETC. (SPECIFY)		17. DECEDENT'S EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED) ELEMENTARY/SECONDARY (0-12) <input type="checkbox"/> COLLEGE (14 OR 5+)		18. FATHER'S NAME (FIRST, MIDDLE, LAST)		19. MOTHER'S NAME (FIRST, MIDDLE, MAIDEN SURNAME)	

**PARENTS****INFORMANT****DISPOSITION****PRONOUNCING OFFICIAL**

ITEMS 27-29 MUST BE COMPLETED BY PHYSICIAN OR NURSE WHO PRONOUNCES DEATH

SEE DEFINITION OF DEATH ON OTHER SIDE

**CERTIFIER**

20A. INFORMANT'S NAME (TYPE/PRINT)		20B. MAILING ADDRESS (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE, ZIP CODE)	
21A. METHOD OF DISPOSITION <input type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> DONATION <input type="checkbox"/> OTHER (SPECIFY)		21B. PLACE OF DISPOSITION (NAME OF CEMETERY, CREMATORY, OR OTHER PLACE)	
21C. LOCATION (CITY, TOWN, STATE)		22A. SIGNATURE OF FUNERAL DIRECTOR	
22B. LICENSE NUMBER (OF LICENSEE)		23. NAME AND ADDRESS OF FACILITY <b>Schoenberg</b>	
24. REGISTRAR'S SIGNATURE		25. DATE FILED (MO., DAY, YR.)	
26. COMPLETE ITEMS 26 A-C ONLY WHEN CERTIFYING PHYSICIAN IS NOT AVAILABLE AT TIME OF DEATH TO CERTIFY CAUSE OF DEATH.		26A. TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE TIME, DATE, AND PLACE STATED SIGNATURE AND TITLE	
27. TIME OF DEATH <b>7:03</b> <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		28. DATE PRONOUNCED DEAD (MO., DAY, YR.) <b>08 - 30 - 02</b>	
29. WAS CASE REFERRED TO MEDICAL EXAMINER? (YES OR NO) <b>YES</b>		26B. LICENSE NUMBER	
26C. DATE SIGNED (MO., DAY, YR.)		30A. CERTIFIER (CHECK ONLY ONE) <input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 26) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying the cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.	
30B. SIGNATURE AND TITLE OF CERTIFIER <b>GLENN STRYJEWski, M.D.</b>		30C. LICENSE NUMBER	
30D. DATE SIGNED (MO., DAY, YR.) <b>8/30/02</b>		31. NAME AND ADDRESS OF CERTIFIER WHO COMPLETED CAUSE OF DEATH (ITEM 40) (TYPE/PRINT) <b>A.I. Dupont Hospital 1600 Rockland Road Wilmington DE 19899</b>	

TO HOSPITAL OR PHYSICIAN — DELAWARE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 72 HOURS AFTER DEATH

32A. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		33. MANNER OF DEATH <input type="checkbox"/> NATURAL <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> UNDETERMINED		34. DATE OF INJURY (MO., DAY, YR.) <b>8/30/02</b>		35. TIME OF INJURY <b>10:00</b> <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		36. DESCRIBE HOW INJURY OCCURRED <b>Child fell into Pool</b>	
32B. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		37. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. (SPECIFY)) <b>Grandparents Home</b>		38. LOCATION (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE) <b>3220 Coachman Rd., Surrey Park, Wilm., DE</b>		39. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		40. PART I DO NOT ENTER THE MODE OF DYING SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE PER EACH LINE.  IMMEDIATE CAUSE (A) <b>Drowning</b> DUE TO (B) DUE TO (C) DUE TO (D)  SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (DISEASE OR INJURY WHICH INITIATED EVENTS RESULTING IN DEATH) LAST  PART II OTHER SIGNIFICANT CONDITIONS— CONTRIBUTING TO CAUSE OF DEATH	

REV. 9/99

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